

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **1911**

BIRTH NO. _____		REG. DIST. NO. <u>217</u>		PRIMARY REG. DIST. NO. <u>3045</u>		Registrar's No. <u>75</u>	
1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Charleston</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Charleston</u>			
c. LENGTH OF STAY (in this place) <u>14 yrs.</u>				d. STREET ADDRESS (If rural, give location) <u>409 S. Elm St.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>409 S. Elm St.</u>				d. STREET ADDRESS (If rural, give location) <u>409 S. Elm St.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Anice</u>		b. (Middle) <u>-----</u>		c. (Last) <u>Hayslett</u>	
4. DATE OF DEATH		(Month) <u>Feb</u>		(Day) <u>3</u>		(Year) <u>1949</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 3, 1900</u>	9. AGE (In years last birthday) <u>48</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>0</u>	IF UNDER 1 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Used Clothing</u>		11. BIRTHPLACE (State or foreign country) <u>Holcomb, Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Henry Betts</u>		13b. MOTHER'S MAIDEN NAME <u>Anice Townsend</u>		14. NAME OF HUSBAND OR WIFE <u>A. R. Hayslett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT'S SIGNATURE OR NAME <u>A.R. Hayslett</u> ADDRESS <u>409 S. Elm, Charleston, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive Heart Disease & RT. Hemiplegia</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Chronic Nephritis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 mos. (est.)</u> <u>4 mos. (est.)</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-24-</u> , 1949, to <u>1-31-</u> , 1949, that I last saw the deceased alive on <u>1-31-</u> , 1949, and that death occurred at <u>5:25A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>M. A. Fingal</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>204 S. Locust St. Charleston</u>		23c. DATE SIGNED <u>Mo. 2-3-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 6, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Charleston, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>2-4-49</u>		REGISTRAR'S SIGNATURE <u>Mrs. John Bondurant</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>F. J. Sparks</u> ADDRESS <u>Charleston, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office No.

District File Number 249

Date Filed 2-8-4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Frank J. Sparks

Licensed Embalmer No. 3450

P. O. Address Cape Girardeau

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.